S-1525.1

SUBSTITUTE SENATE BILL 5425

State of Washington 56th Legislature 1999 Regular Session

By Senate Committee on Health & Long-Term Care (originally sponsored by Senators Thibaudeau, Long, Wojahn, Winsley, Costa, Oke, Franklin, McCaslin, Kohl-Welles, Swecker, Hargrove, Prentice, McAuliffe, Fairley, Kline, Fraser, Haugen, Eide, Goings, Brown, Shin, Jacobsen, Patterson, Bauer, Gardner, Heavey, B. Sheldon, T. Sheldon, Rasmussen, Loveland, Hale, Spanel and Snyder)

Read first time 02/22/1999.

1 AN ACT Relating to mental health parity; amending RCW 48.21.240,
2 48.44.340, and 48.46.290; adding a new section to chapter 41.05 RCW;
3 adding a new section to chapter 48.21 RCW; adding a new section to
4 chapter 48.44 RCW; adding a new section to chapter 48.46 RCW; adding a
5 new section to chapter 70.47 RCW; creating a new section; and repealing
6 RCW 48.21.240, 48.44.340, and 48.46.290.

7 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

8 NEW SECTION. **Sec. 1.** National data suggest that in any given year
9 one in ten adult Americans experiences a mental disorder, and one in
10 five adult Americans will have a mental disorder during his or her
11 lifetime that requires treatment. For children, data suggest that one
12 in five may have a diagnosable mental disorder. Mental disorders are
13 just as preventable, controllable, or curable as physical disorders.
14 The legislature finds that the costs for leaving mental disorders
15 untreated or undertreated are enormous, and often include: Decreased
16 job productivity, increased job turnover, loss of employment, increased
17 disability costs, deteriorating school performance, increased use of
18 other health care services, treatment delays leading to more costly
19 treatments, suicide, family breakdown and impoverishment, and

institutionalization, whether in hospitals, juvenile detention, jails, or prisons.

Therefore, the legislature declares that it is no longer cost-effective to treat persons with mental disorders differently than persons with medical and surgical disorders. The cost to our children, families, businesses, and society as a whole is too high.

Therefore, the legislature intends to require insurance coverage at parity for mental health services, which means that this coverage be delivered under the same terms and conditions as medical and surgical coverage.

NEW SECTION. **Sec. 2.** A new section is added to chapter 41.05 RCW to read as follows:

(1) For the purpose of this section, "mental health services" means: (a) Outpatient and inpatient services provided to treat any of the mental disorders covered by the diagnostic categories listed in the most current version of the diagnostic and statistical manual of mental disorders on the effective date of this section, or such subsequent date as may be provided by the authority by rule, consistent with the purposes of chapter . . ., Laws of 1999 (this act), except V codes and those codes defining substance abuse disorders, 291.0 through 292.9 and 303.0 through 305.9 as of the effective date of this section; and (b) prescription drugs, if the plan contract otherwise includes coverage for prescription drugs.

(2) Each health plan offered to public employees and their covered dependents under this chapter that is not subject to the provisions of Title 48 RCW and is established or renewed after January 1, 2001, and that provides coverage for hospital or medical care, shall provide coverage for mental health services. This coverage:

(a) Shall only impose treatment limitations or financial requirements on coverage for mental health services, if the same limitations or requirements are imposed on coverage for medical and surgical services. This includes but is not limited to copays, cost sharing, annual or lifetime dollar limits, outpatient visit limits, outpatient day limits, and inpatient limits. Wellness and preventive services that are reimbursed at one hundred percent without deductible, coinsurance, or other cost sharing are excluded from this comparison; and

(b) Shall require one single annual deductible, and one single annual maximum out-of-pocket limit for medical and surgical and mental health services if annual deductibles and maximum out-of-pocket limits are required by the insuring entity. However, no plan is required to initiate the use of such a deductible or limit.

(3) This section does not prohibit an insuring entity from requiring the use of preauthorization screening prior to authorizing the delivery of mental health services or the requirement that mental health services must be medically necessary as determined by its medical director or his or her designee.

NEW SECTION. **Sec. 3.** A new section is added to chapter 48.21 RCW to read as follows:

(1) For the purpose of this section, "mental health services" means: (a) Outpatient and inpatient services provided to treat any of the mental disorders covered by the diagnostic categories listed in the most current version of the diagnostic and statistical manual of mental disorders on the effective date of this section or such subsequent date as may be provided by the insurance commissioner by rule, consistent with the purposes of chapter . . ., Laws of 1999 (this act), except V codes and those codes defining substance abuse disorders, 291.0 through 292.9 and 303.0 through 305.9 as of the effective date of this section; and (b) prescription drugs, if the insurance contract otherwise includes coverage for prescription drugs.

(2) All group disability insurance contracts and blanket disability insurance contracts providing health care services to groups with more than fifty persons, issued or renewed after January 1, 2001, and for groups with fifty or fewer persons, issued or renewed after January 1, 2002, that provide coverage for hospital or medical care shall provide coverage for mental health services. This coverage:

(a) Shall only impose treatment limitations or financial requirements on coverage for mental health services, if the same limitations or requirements are imposed on coverage for medical and surgical services. This includes but is not limited to copays, cost sharing, annual or lifetime dollar limits, outpatient visit limits, outpatient day limits, and inpatient limits. Wellness and preventive services that are reimbursed at one hundred percent without deductible, coinsurance, or other cost sharing are excluded from this comparison; and

1 (b) Shall require one single annual deductible, and one single
2 annual maximum out-of-pocket limit for medical and surgical and mental
3 health services if annual deductibles and maximum out-of-pocket limits
4 are required by the insurer. However, no plan is required to initiate
5 the use of such a deductible or limit.
6 (3) This section does not prohibit an insurer from requiring the
7 use of preauthorization screening prior to authorizing the delivery of
8 mental health services or the requirement that mental health services
9 must be medically necessary as determined by its medical director or
10 his or her designee.

11 NEW SECTION. **Sec. 4.** A new section is added to chapter 48.44 RCW
12 to read as follows:
13 (1) For the purpose of this section, "mental health services"
14 means: (a) Outpatient and inpatient services provided to treat any of
15 the mental disorders covered by the diagnostic categories listed in the
16 most current version of the diagnostic and statistical manual of mental
17 disorders on the effective date of this section, or such subsequent
18 date as may be provided by the insurance commissioner by rule,
19 consistent with the purposes of chapter . . ., Laws of 1999 (this act),
20 except V codes and those codes defining substance abuse disorders,
21 291.0 through 292.9 and 303.0 through 305.9 as of the effective date of
22 this section; and (b) prescription drugs, if the contract otherwise
23 includes coverage for prescription drugs.
24 (2) All health care service contracts for groups with more than
25 fifty persons, issued or renewed after January 1, 2001, and for groups
26 with fifty or fewer persons, issued or renewed after January 1, 2002,
27 that provide coverage for hospital or medical care shall provide
28 coverage for mental health services. This coverage:
29 (a) Shall only impose treatment limitations or financial
30 requirements on coverage for mental health services, if the same
31 limitations or requirements are imposed on coverage for medical and
32 surgical services. This includes but is not limited to copays, cost
33 sharing, annual or lifetime dollar limits, outpatient visit limits,
34 outpatient day limits, and inpatient limits. Wellness and preventive
35 services that are reimbursed at one hundred percent without deductible,
36 coinsurance, or other cost sharing are excluded from this comparison;
37 and

(b) Shall require one single annual deductible, and one single annual maximum out-of-pocket limit for medical and surgical and mental health services if annual deductibles and maximum out-of-pocket limits are required by the health care service contractor. However, no plan is required to initiate the use of such a deductible or limit.

(3) This section does not prohibit a health care service contractor from requiring the use of preauthorization screening prior to authorizing the delivery of mental health services or the requirement that mental health services must be medically necessary as determined by its medical director or his or her designee.

NEW SECTION. **Sec. 5.** A new section is added to chapter 48.46 RCW to read as follows:

(1) For the purpose of this section, "mental health services" means: (a) Outpatient and inpatient services provided to treat any of the mental disorders covered by the diagnostic categories listed in the most current version of the diagnostic and statistical manual of mental disorders on the effective date of this section, or such subsequent date as may be provided by the insurance commissioner by rule, consistent with the purposes of chapter . . ., Laws of 1999 (this act), except V codes and those codes defining substance abuse disorders, 291.0 through 292.9 and 303.0 through 305.9 as of the effective date of this section; and (b) prescription drugs, if the plan contract otherwise includes coverage for prescription drugs.

(2) All health benefit plans offered by health maintenance organizations to groups with more than fifty persons, issued or renewed after January 1, 2001, and for groups with fifty or fewer persons, issued or renewed after January 1, 2002, that provide coverage for hospital or medical care shall provide coverage for mental health services. This coverage:

(a) Shall only impose treatment limitations or financial requirements on coverage for mental health services, if the same limitations or requirements are imposed on coverage for medical and surgical services. This includes but is not limited to copays, cost sharing, annual or lifetime dollar limits, outpatient visit limits, outpatient day limits, and inpatient limits. Wellness and preventive services that are reimbursed at one hundred percent without deductible, coinsurance, or other cost sharing are excluded from this comparison; and

(b) Shall require one single annual deductible, and one single annual maximum out-of-pocket limit for medical and surgical and mental health services if annual deductibles and maximum out-of-pocket limits are required by the health maintenance organization. However, no plan is required to initiate the use of such a deductible or limit.

(3) This section does not prohibit a health maintenance organization from requiring the use of preauthorization screening prior to authorizing the delivery of mental health services or the requirement that mental health services must be medically necessary as determined by its medical director or his or her designee.

NEW SECTION. **Sec. 6.** A new section is added to chapter 70.47 RCW to read as follows:

Notwithstanding the provisions of RCW 70.47.060, this section governs the provision of mental health services to subsidized enrollees in the basic health plan.

(1) For the purpose of this section, "mental health services" means: (a) Outpatient and inpatient services provided to treat any of the mental disorders covered by the diagnostic categories listed in the most current version of the diagnostic and statistical manual of mental disorders on the effective date of this section, or such subsequent date as may be provided by the Washington state health care authority by rule, consistent with the purposes of chapter . . ., Laws of 1999 (this act), except V codes and those codes defining substance abuse disorders, 291.0 through 292.9 and 303.0 through 305.9 as of the effective date of this section; and (b) prescription drugs, if the plan contract otherwise includes coverage for prescription drugs.

(2) After January 1, 2002, the basic health plan shall provide coverage for mental health services to subsidized children and adults. This coverage:

(a) Shall only impose treatment limitations or financial requirements on coverage for mental health services, if the same limitations or requirements are imposed on coverage for medical and surgical services. This includes but is not limited to copays, cost sharing, annual or lifetime dollar limits, outpatient visit limits, outpatient day limits, and inpatient limits. Wellness and preventive services that are reimbursed at one hundred percent without deductible, coinsurance, or other cost sharing are excluded from this comparison; and

1 (b) Shall require one single annual deductible, and one single
2 annual maximum out-of-pocket limit for medical and surgical and mental
3 health services if annual deductibles and maximum out-of-pocket limits
4 are required by the administrator. However, no plan is required to
5 initiate the use of such a deductible or limit.
6 (3) This section does not prohibit the administrator from requiring
7 the use of preauthorization screening prior to authorizing the delivery
8 of mental health services or the requirement that mental health
9 services must be medically necessary as determined by its medical
10 director or his or her designee.
11 (4) This section does not apply to the nonsubsidized basic health
12 plan.

13 **Sec. 7.** RCW 48.21.240 and 1987 c 283 s 3 are each amended to read
14 as follows:
15 (1) Each group insurer providing disability insurance coverage in
16 this state for hospital or medical care under contracts which are
17 issued, delivered, or renewed in this state on or after July 1, 1986,
18 shall offer optional supplemental coverage for mental health treatment
19 for the insured and the insured's covered dependents.
20 (2) Benefits shall be provided under the optional supplemental
21 coverage for mental health treatment whether treatment is rendered by:
22 (a) A physician licensed under chapter 18.71 or 18.57 RCW; (b) a
23 psychologist licensed under chapter 18.83 RCW; (c) a community mental
24 health agency licensed by the department of social and health services
25 pursuant to chapter 71.24 RCW; or (d) a state hospital as defined in
26 RCW 72.23.010. The treatment shall be covered at the usual and
27 customary rates for such treatment. The insurer, health care service
28 contractor, or health maintenance organization providing optional
29 coverage under the provisions of this section for mental health
30 services may establish separate usual and customary rates for services
31 rendered by physicians licensed under chapter 18.71 or 18.57 RCW,
32 psychologists licensed under chapter 18.83 RCW, and community mental
33 health centers licensed under chapter 71.24 RCW and state hospitals as
34 defined in RCW 72.23.010. However, the treatment may be subject to
35 contract provisions with respect to reasonable deductible amounts or
36 copayments. In order to qualify for coverage under this section, a
37 licensed community mental health agency shall have in effect a plan for
38 quality assurance and peer review, and the treatment shall be

supervised by a physician licensed under chapter 18.71 or 18.57 RCW or by a psychologist licensed under chapter 18.83 RCW.

(3) The group disability insurance contract may provide that all the coverage for mental health treatment is waived for all covered members if the contract holder so states in advance in writing to the insurer.

(4) This section shall not apply to a group disability insurance contract that has been entered into in accordance with a collective bargaining agreement between management and labor representatives prior to March 1, 1987.

(5) This section does not apply to groups with more than fifty persons beginning January 1, 2001.

Sec. 8. RCW 48.44.340 and 1987 c 283 s 4 are each amended to read as follows:

(1) Each health care service contractor providing hospital or medical services or benefits in this state under group contracts for health care services under this chapter which are issued, delivered, or renewed in this state on or after July 1, 1986, shall offer optional supplemental coverage for mental health treatment for the insured and the insured's covered dependents.

(2) Benefits shall be provided under the optional supplemental coverage for mental health treatment whether treatment is rendered by: (a) A physician licensed under chapter 18.71 or 18.57 RCW; (b) a psychologist licensed under chapter 18.83 RCW; (c) a community mental health agency licensed by the department of social and health services pursuant to chapter 71.24 RCW; or (d) a state hospital as defined in RCW 72.23.010. The treatment shall be covered at the usual and customary rates for such treatment. The insurer, health care service contractor, or health maintenance organization providing optional coverage under the provisions of this section for mental health services may establish separate usual and customary rates for services rendered by physicians licensed under chapter 18.71 or 18.57 RCW, psychologists licensed under chapter 18.83 RCW, and community mental health centers licensed under chapter 71.24 RCW and state hospitals as defined in RCW 72.23.010. However, the treatment may be subject to contract provisions with respect to reasonable deductible amounts or copayments. In order to qualify for coverage under this section, a licensed community mental health agency shall have in effect a plan for

quality assurance and peer review, and the treatment shall be supervised by a physician licensed under chapter 18.71 or 18.57 RCW or by a psychologist licensed under chapter 18.83 RCW.

(3) The group contract for health care services may provide that all the coverage for mental health treatment is waived for all covered members if the contract holder so states in advance in writing to the health care service contractor.

(4) This section shall not apply to a group health care service contract that has been entered into in accordance with a collective bargaining agreement between management and labor representatives prior to March 1, 1987.

(5) This section does not apply to groups with more than fifty persons beginning January 1, 2001.

Sec. 9. RCW 48.46.290 and 1987 c 283 s 5 are each amended to read as follows:

(1) Each health maintenance organization providing services or benefits for hospital or medical care coverage in this state under group health maintenance agreements which are issued, delivered, or renewed in this state on or after July 1, 1986, shall offer optional supplemental coverage for mental health treatment to the enrolled participant and the enrolled participant's covered dependents.

(2) Benefits shall be provided under the optional supplemental coverage for mental health treatment whether treatment is rendered by the health maintenance organization or the health maintenance organization refers the enrolled participant or the enrolled participant's covered dependents for treatment to: (a) A physician licensed under chapter 18.71 or 18.57 RCW; (b) a psychologist licensed under chapter 18.83 RCW; (c) a community mental health agency licensed by the department of social and health services pursuant to chapter 71.24 RCW; or (d) a state hospital as defined in RCW 72.23.010. The treatment shall be covered at the usual and customary rates for such treatment. The insurer, health care service contractor, or health maintenance organization providing optional coverage under the provisions of this section for mental health services may establish separate usual and customary rates for services rendered by physicians licensed under chapter 18.71 or 18.57 RCW, psychologists licensed under chapter 18.83 RCW, and community mental health centers licensed under chapter 71.24 RCW and state hospitals as defined in RCW 72.23.010.

However, the treatment may be subject to contract provisions with respect to reasonable deductible amounts or copayments. In order to qualify for coverage under this section, a licensed community mental health agency shall have in effect a plan for quality assurance and peer review, and the treatment shall be supervised by a physician licensed under chapter 18.71 or 18.57 RCW or by a psychologist licensed under chapter 18.83 RCW.

(3) The group health maintenance agreement may provide that all the coverage for mental health treatment is waived for all covered members if the contract holder so states in advance in writing to the health maintenance organization.

(4) This section shall not apply to a group health maintenance agreement that has been entered into in accordance with a collective bargaining agreement between management and labor representatives prior to March 1, 1987.

(5) This section does not apply to groups with more than fifty persons beginning January 1, 2001.

NEW SECTION. **Sec. 10.** The following acts or parts of acts are each repealed, effective January 1, 2002:

(1) RCW 48.21.240 (Mental health treatment, optional supplemental coverage--Waiver) and 1987 c 283 s 3, 1986 c 184 s 2, 1983 c 35 s 1, & section 7 of this act;

(2) RCW 48.44.340 (Mental health treatment, optional supplemental coverage--Waiver) and 1987 c 283 s 4, 1986 c 184 s 3, 1983 c 35 s 2, & section 8 of this act; and

(3) RCW 48.46.290 (Mental health treatment, optional supplemental coverage--Waiver) and 1987 c 283 s 5, 1986 c 184 s 4, 1983 c 35 s 3, & section 9 of this act.

NEW SECTION. **Sec. 11.** If any provision of this act or its application to any person or circumstance is held invalid, the remainder of the act or the application of the provision to other persons or circumstances is not affected.

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